PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, October 30, 2001, at 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard K. Koh, (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Benjamin Rubin, Ms. Janet Slemenda and Dr. Thomas Sterne; Ms. Maureen Pompeo absent (One vacancy). Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½. In addition, Chairman Koh noted New Business items, two presentations: "A BioTerrorism Update" and "The Prioritization of Influenza Vaccine."

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Paul Dreyer, Director, Division of Health Care Quality, Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management, Ms. Joyce James, Director, Determination of Need Program; Dr. Alfred DeMaria, Assistant Commissioner, Bureau of Communicable Disease Control and Dr. Susan Lett, Director, Massachusetts Immunization Program.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETING OF AUGUST 21, 2001:

Records of the Public Health Council Meeting of August 21, 2001 were presented. After consideration, upon motion made and duly seconded, it was voted unanimously: That, records of the Public Health Council meeting of August 21, 2001, copies of which were sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A ½.

PERSONNEL ACTIONS:

In a letter dated October 4, 2001, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments to the allied and active medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously: That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the allied and active medical staffs of Tewksbury Hospital, be approved for a period of two years beginning October 1, 2001 to October 1, 2003:

NAME:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
James Thompson, MD	73230	Active
John Duggan, OD	2186	Allied

"THE ROLE OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH IN PROMOTING PATIENT SAFETY AND PREVENTING MEDICAL ERRORS", BY NANCY RIDLEY, ASSISTANT COMMISSIONER, BUREAU OF HEALTH QUALITY MANAGEMENT:

In cooperation with a coalition of health care professionals, government officials, professional organizations, legislators and consumers, the Massachusetts Department of Public Health has been awarded a three-year, $4.5 million federal grant to develop strategies to increase patient protection by evaluating and improving the Massachusetts system for reporting medical errors. The grant was awarded by the Agency for Health Resources and Quality, a branch of the United States Department of Health and Human Services. Massachusetts is a recognized leader in the area of patient safety and was the first state in the nation to convene a public/ private coalition to promote patient safety and prevent medical errors. The project will address key unanswered questions about how errors occur and provide science-based information on what patients, clinicians, hospital leaders, policymakers and others can do to make the health care system safer. The results of this research will identify improvement strategies that work in hospitals, doctors' offices, nursing homes, and other health care settings across the nation. This grant is part of a recently announced initiative by the United States Department of Health and Human Services to fund 94 new research grants, contracts and other projects to reduce medical errors and improve patient safety. Ten of these grants have been awarded in Massachusetts. The initiative represents the federal government's largest single investment to address the estimated 44,000 to 98,000 patient deaths nationwide related to medical errors each year. The 94 projects now being funded will be carried out at state agencies, major universities, hospitals, outpatient clinics, nursing homes, physicians'offices, professional societies, and other organizations across the country. The goals of the project include evaluation of the current Massachusetts system for reporting medical errors, recommendations on improvements to the system infrastructure, development of Best Practice initiatives to improve patient safety in hospitals, communication of patient safety information, and evaluation of methods used to disclose information to patients and family members regarding medical errors that have occurred.

The medical errors demonstration project will be accomplished through the use of a coordinated team of academic researchers working in collaboration with the Massachusetts Department of Public Health and the Massachusetts Coalition for the Prevention of Medical Errors…In addition to the Massachusetts Department of Public Health and the Coalition, scientific and technical direction will be provided by Arnold

Epstein, M.D., Lucian Leape, M.D., Harvard School of Public Health and Joel Weissman, PhD, Massachusetts General Hospital, Institute for Health Policy. Other investigators actively involved in the project include Jack Fowler, Ph.D., Center for Survey Research, University of Massachusetts Boston, Eric Schneider, M.D., Harvard Medical School and the Massachusetts Hospital Association. A technical advisory panel has been established and includes MaryAnna Sullivan, M.D., Chairman of the Massachusetts Board of Registration in Medicine Patient Care Assessment Committee; Trish Riley, Executive Director of the National Academy of State Health Policy and Senator Richard Moore, Chairman of the Massachusetts Joint Committee on Health Care. Massachusetts hospitals must report to the Massachusetts Department of Public Health any serious injury to a patient which means injury that is life threatening, results in death or requires a patient to undergo significant additional diagnostic or treatment measures. Hospitals must also report maternal deaths occurring within 90 days of delivery and serious incidents that result in serious injury not anticipated including medical errors, equipment malfunction or user errors, reportable infections, disease outbreaks and poisonings occurring within the facility. In the year 2000, the Massachusetts Department of Public Health received a total of 883 reports of serious incidents or consumer complaints relative to hospitals. Reporting of such incidents increased dramatically following the well-publicized Dana Farber chemotherapy incident in 1995, and prompted the 1997 formation of the statewide Coalition for the Prevention of Medical Errors.

Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management, said in part, "…In putting together this request for a grant to the Federal Government last spring, we engaged a series of academic researchers, institutional partners, and the Coalition for the Prevention of Medical Errors …One of the issues that we are most heavily involved in here in Massachusetts has been the power of prevention. We try to build prevention into every single program that we put forth, even those that are regulatory and protection oriented and have generally taken on not the traditional type of prevention mentality. We have tried to change that paradigm. …We try to clone some of the responses and the best practices that we see, and really develop a proactive rather than a reactive approach in our goal of preventing medical errors from occurring….In 1999, the Institute of Medicine estimated that there were between forty-four thousand and ninety-eight thousand deaths per year that were occurring from medical errors. The number shocked a lot of people. It got a lot of media attention. Here in Massachusetts, because a lot of the preliminary research had been done here, it did not shock us so much as really make us realize that some of the efforts that we had started were actually ones that needed to be sort of cloned and put forth across the country in terms of forming coalitions for prevention. There was a follow-up report that came out this past March, 'Crossing the Quality Chasm,' which broadens a lot of the issues that needed to be pulled together in looking at patient safety….There was obviously increased public awareness due to the media. Issues of confidentiality of some of the information from a peer review standpoint, as well as from a public and patient standpoint, became a key and critical issue. Ownership-who owned the issue of public safety? Well, it was one of the things we had to do to bring everybody together to say that it is really a shared responsibility. No one owns the coalition. No one owns the problems and the issues of creating a safe patient environment. There were obviously the problems. You have multiple oversight

bodies. The Department of Public Health is not the only entity in the game of regulating health care. You have the Joint Commission. You have the Boards of Registration. You have multiple agencies that have reporting and regulatory oversight and responsibility. We needed to have all of those individuals at the table.…."

Ms. Ridley continued, "…What we were attempting to do in the beginning is to change the culture of fear to a culture of safety so that people would not be afraid to report bad things that happen to what are normally good people and good institutions, and to change the culture of denial to one of learning. And that has been the basic premise for a lot of the work we have done through the Coalition….The wide variety of organizations that we have sitting around the table at the Coalition with the shared mutual goal of patient safety, of establishing a safe patient environment, includes public, private, professional researchers, insurers, purchasers and payers, as well as consumers. We have had some very positive results. We have had very good media recognition for the work of the Coalition and the collective work that is being done in promoting patient safety. …We have learned a lot about communication which plays a role, in no matter what you are doing, and we are finding out with our current work with emergency response in bio-terrorism that it is as important there as it is in patient safety in general. You really need to learn from others. You need to involve clinicians in the whole process. You need to strike a balance. You need to engage the media. You cannot be afraid of the media. They are as important in communicating safety information and good information to the public as we are. You have to recognize that everybody does have a seat at the table. Priorities for the Coalition itself have been to look at best practices, focus on prevention strategies, increase public participation, improve education and training….Massachusetts is one of fifteen states across the country that has mandatory reporting of medical errors to a state agency. There are only eight of those fifteen across the county that have a system of reporting that is as comprehensive or flushed out as the one in Massachusetts. You had to have a system in order to apply for the grant. Basically, the purpose of the grant is to evaluate and improve upon the system that we have. We can learn from the system that we have got. We have some academic researchers that are involved, that will help us learn from the system we have. There is a lot of work that is going on across the country in terms of trying to come up with indicators and definitions of what types of medical errors and serious incidents and events should be reported to a state-based system. The National Quality Forum is working to try to put together drafts of these. We are hoping that studying systems such as ours, improving them, perhaps going electronic with it, will help to set a model for the rest of the country because, the eight systems that exist are very different. There is no single model. They vary in all aspects. One of the goals in this grant will be to establish some models for other states on what works, what does not work, what improvements can be made across the country….Some of the projects that we are going to do with developing best practices here have to do with transfusion-related injuries and death, wrong side, wrong site, wrong patient procedures that are done in hospital settings. Some other best practices will be researched and best practices will be developed for such things as public disclosure, patient disclosure….The Joint Commission came out with a standard this summer where patients must be informed of outcomes that are not expected, and we are going to be taking a closer look at trying to come up with some model best practices in this area as well. The third part of

the grant will be what does the public reporting system accomplish and we will be taking a look at survey hospital executives, risk managers, legal counsels both here in Massachusetts as well as across the country. We will also be looking at depth here at what are those model practices, or what are the practices and policies that are in place for informing patients about medical errors and things that go wrong. The fourth part of the grant will be to actually do a survey of patients. We will be doing a survey of recently discharged patients for their perceptions and knowledge of medical errors, patient safety, and whether or not they may have experienced problems when they were in the hospital during their recent stay. And there will be a lot of in depth work between the Institute for Health Policy and Harvard School of Public Health in terms of going back and taking a look to see what the reality is in terms of the patient care in these instances. Congress wanted to have work done within the grants, if possible, on the issue about public disclosure and patient disclosure, and it is something that the federal government and the Agency for Health Research and Quality are very interested in finding out about the patient's role…. In calendar year 2000, we had about fourteen thousand events reported to us, either by patients and family members, or by the facilities themselves. This includes hospitals, nursing homes, clinics, and other types of facilities. In hospitals, we have about 77 acute care hospitals, and about a thousand of the events come from hospitals. The vast majority are from nursing homes….In conclusion I just want to say that we have an unbelievable record where ten out of the 94 grants are actually to researchers and institutions here in Massachusetts. We received one of the larger ones… Massachusetts is rich and is really following through on its reputation of being leaders across the board. And we are very pleased for the Department to be part of that."

NO VOTE - INFORMATIONAL ONLY

"BIO-TERRORISM UPDATE" - BY DR. HOWARD K. KOH, M.D., M.P.H., COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH:

Chairman Howard K. Koh, M.D. presented a "Bio-Terrorism Update." Chairman Koh said, "Because it is so timely, I would like to spend several minutes updating the Council Members on anti bio-terrorism efforts in the Commonwealth. There are some basic themes and messages we have been trying to promote over the last several weeks, and I will update you on those. From a statewide perspective, we are facing an unprecedented challenge, but I can assure you the state officials have mounted an unprecedented response. Over the last number of weeks, officials in Public Health have worked very closely with officials in Public Safety, with Fire, with Police, with the National Guard, with the FBI, now with officials from the meetings led by the Governor. There is intensive collaboration with local health officials around the Commonwealth, particularly with the City of Boston. I cannot say enough about our colleagues at the State Laboratory. They are literally working seven days a week. The Laboratory has now processed fourteen hundred samples from around the state. All tested negative, and we are virtually caught up with our backlog. I want to thank our colleagues at the Laboratory who have worked so professionally to meet this challenge. We again continue to stress that, as of today, there are no cases of anthrax in our Commonwealth. There are no infections. There are no documented exposures. Nationwide there are three

tragic deaths to date. We continue to have intense collaboration with all of our partners to continue to educate the public, to educate the health professionals, and to protect the people of Massachusetts. Let me quickly update everyone in terms of our education efforts with respect to health care professional education. We are working closely with physicians and the Medical Society, with hospitals and the Hospital Association, the community health centers, with the health plans, with the nurses…Our Department is doing onsite training of emergency room based physicians. Dr. DeMaria, our State Epidemiologist, continues to have intense interaction with infectious disease specialists around the state to improve the medical education.

Chairman Koh continued, "We have a DPH web site, which has been updated about six or seven times with clinical advisories, sent to us by the CDC. That web site is www.state.ma.us/dph. We have a DPH information line, 866-627-7968. And, of course, our State Laboratory colleagues are on call twenty-four hours a day, as is our State Epidemiologist. As of tomorrow, we will have completed five regional meetings around the state that involve public health officials, local health officials, public safety, fire, police, emergency medical personnel. These meetings have been very well received. We have had tremendous attendance, up to four hundred people at each meeting. So that education is ongoing. I personally am working very closely with the Postal Service in terms of their environmental testing at their Boston site, and those results should be available within the next several days. Our most important efforts and our most important challenge continues to be risk communication. I am very grateful to the major Boston newspapers, The Boston Herald and The Boston Globe, who have donated the cost of full page advertisements and the Department of Public Health and the Boston Public Health Commission will be co-sponsoring these ads which, hopefully, will be appearing within the next several days. The ad is entitled, What You Need to Know About Bio-Terrorism. There are several major points. To date there have been no bio-terrorism events in Massachusetts. The risk to the general public remains very low. If bio-terrorism occurs in Massachusetts, we will respond immediately, and then some suggestions about what every person can do in our state to take a common sense approach in dealing with suspicious materials or objects. We are asking people not to stockpile antibiotics. We are asking everyone to take especially good care of themselves during this very stressful time, and we are asking everybody to continue to familiarize themselves with the many resources available that can provide basic information about anthrax in particular, and bioterrorism in general. I also want to stress that we are working very closely with the Massachusetts Emergency Management Agency, MEMA, …and our communications with federal officials continue to be very intense and very collaborative and productive. So, that is the status of our efforts to date. I want to take this opportunity to thank all of our colleagues throughout the state, our colleagues in Public Health, in Public Safety, in law enforcement, local health officials. This has truly been an unprecedented collaboration and unprecedented response and I am very, very proud."

NO VOTE – INFORMATIONAL ONLY

"INFLUENZA VACCINE UPDATE" – BY DR. ALFRED DEMARIA, ASSISTANT COMMISSIONER, BUREAU OF COMMUNICABLE DISEASE CONTROL AND DR. SUSAN LETT, DIRECTOR, MASSACHUSETTS IMMUNIZATION PROGRAM:

Dr. Alfred DeMaria, Assistant Commissioner, Division of Communicable Disease Control Program, introduced the Influenza Vaccine Update. He said, "It's a pleasure to update the Council on influenza vaccine supply. And while we hope that the bio-terrorism events will end, and will never reach Massachusetts, one thing we know for sure is that, to some degree, influenza will reach Massachusetts…. The public supply of vaccine is in. There is vaccine in the private sector, as well, available to agencies, organizations and employers. We want to reiterate the priorities and the need to target the highest risk citizens in Massachusetts for immunization against influenza…"

Dr. Susan Lett, Director, Massachusetts Immunization Program, said in part, "The Massachusetts Department of Public Health has received its final shipment of influenza vaccine, bringing the total number of doses of state-supplied influenza vaccine to 740,000. This is 62,000 more doses of state-supplied flu vaccine than was distributed last year. These doses will be distributed to local health departments and other health care providers over the next week. Flu vaccine is the best way to prevent influenza. It is especially important for people at risk for complications from influenza and the people who live with them to call their health care provider or local health department to arrange to get their flu vaccine. While the best time to get vaccinated is in October or November, people who have not received the vaccine can be vaccinated throughout the flu season which, in Massachusetts, last until March or even April. Public health officials reiterated their message that November and December is not too late to get vaccinated against influenza. Influenza season in New England usually does not get started until late December, and does not peak until January or February. As of October 26, 2001, no confirmed cases of influenza had been reported to the Department of Public Health yet this season."

Dr. Lett continued, "During the 2001-2002 season, influenza vaccine will again be delayed and will be distributed in multiple shipments. The Massachusetts Immunization Program (MIP) has been notified that it will most likely not receive the bulk of its vaccine until late October. To ensure that influenza vaccine is administered first to those who need it most, all health care providers should implement the following recommendations for the use of both state-supplied and privately purchased vaccine. In the event of further delays or a shortage, the MIP will issue additional guidance. Administer influenza vaccine according to the following prioritization:

Group 1: Persons at highest risk for complications from influenza.

- All adults $\geq$ 65 years of age.

- Residents in long-term care facilities housing persons with chronic medical conditions.
- People six months through 64 years of age: with chronic pulmonary or cardiovascular disease, including asthma; or who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes); renal dysfunction; hemoglobinopathies; HIV infection; or immunosupression caused by other diseases, medications or treatments.
- Children and adolescents (aged 6 months to 18 years of age) receiving long-term aspirin therapy.
- Women who will be in the second or third trimester of pregnancy during the flu season.

Group 2: Health care workers, ancillary staff and volunteers who could transmit influenza to persons at highest risk.

- Physicians, nurses and other personnel in hospitals and outpatient-care settings; emergency response workers; and employees of long-term care facilities and assisted living residences who have contact with patients or residents.

Note: State-supplied influenza vaccine should not be used for employees who are not otherwise included in Groups 1,3 and 4. Employee immunizations are the responsibility of the employer. Employers, including municipalities, who wish to immunize their employees should purchase the vaccine.

Group 3: Household members, including children, of persons in Group 1.

Group 4: Persons 50-64 years of age who are not included in the groups above.

Group 5: If vaccine is still available, vaccinate anyone who wishes to reduce the likelihood of becoming ill with influenza.

Timing of Annual Influenza Vaccination

In September or as soon as vaccine is available:

- Primary care sites, medical specialty practices, home health agencies and hospitals: Vaccinate persons in Group 1 when they are seen for routine health care or are hospitalized. Develop plans to continue vaccinating Group 1 throughout the flu season (October – March).

October:

- Long-term care facilities: Vaccinate all residents and employees. Note: State-supplied vaccine should not be used for employees at this time.

- All inpatient and outpatient health care facilities, home health agencies, assisted living facilities and programs for the homeless: Vaccinate persons in Groups 1 and 2. Note: State-supplied vaccine should not be used for employees at this time.

- Organized vaccination clinics: Hold clinics at sites where only persons in Group 1 will attend, such as senior housing units or special residential programs. Schedule larger organized immunization campaigns beginning in early November and only after receipt of vaccine.

November:

- Long-term care facilities: Continue to vaccinate new admissions and new hires.

- All inpatient and outpatient health care facilities, home health agencies, assisted living facilities and programs for the homeless: Continue to vaccinate Groups 1 and 2 and begin to vaccinate Groups 3 and 4. If sufficient vaccine is available, begin vaccinating Group 5

- Organized vaccination clinics: Hold organized clinics to immunize Groups 1, 3 and 4. If sufficient vaccine is available, vaccinate Group 5.

- Non-Medical Facility Worksites: Begin vaccinating employees. Note: State-supplied vaccine should not be used for employees at this time.

December through March:

- All sites and facilities: Continue vaccinating Groups 1-5 throughout the flu season.

Note: Beginning in December, once all of your high-risk patients have been vaccinated, state-supplied influenza may be used for health care workers.

Other Recommendations

- Administer pneumococcal vaccine (PPV23) to people at risk for pneumococcal disease. Pneumococcal vaccine prevents invasive pneumococcal disease, a common complication of influenza. People at risk for pneumococcal disease include everyone 65 years of age and older, people younger than 65 with certain chronic medical conditions, and residents of long-term care facilities. PPV23 is available at no charge from the MIP for patients at risk for pneumococcal disease.

- Coordination: All health care providers are encouraged to coordinate with each other, their local health department and others in their community to ensure that both state-supplied and privately purchased vaccine is administered first to the highest risk members in their community.

NO VOTE – INFORMATIONAL ONLY

DETERMINATION OF NEED PROGRAM:

INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENT TO DON EXPENDITURE MINIMUMS:

Ms. Joyce James, Director, Determination of Need Program, said in part, "…The purpose of this memorandum is to request the Public Health Council's adoption of the Informational Bulletin of Annual Adjustments to the Determination of Need Expenditure Minimums. These adjustments are being requested in compliance with M.G.L. c.111, s.25B ½. Since the U.S. Department of Health and Human Services does not have an appropriate index, the inflation indices used by the DoN Program staff to adjust DoN threshold dollar amounts are:

Marshall & Swift ……capital costs
DRI/McGraw Hill*……..operating costs
(*Standard & Poor's DRI Health Care Cost Review)

These indices have been chosen by the Determination of Need Program as an authoritative resource due to their extensive use with the health care industry to determine inflation rates for a number of health care expenditures. While each of the indices has various regional and market sector subtleties and shadings, it is important for ease of administration to use a single inflation factor for capital costs and a single factor for operating costs. Thus, Marshall and Swift's statewide figures are used for the capital cost inflation and the average of DRI/McGraw-Hill hospital and nursing home figures is used as the basis for recalculating inflated operating costs…."

After consideration, upon motion made and duly seconded, it was voted unanimously that the **Informational Bulletin on Annual Adjustment to DoN Expenditure Minimums be approved.**

The meeting adjourned at 11:00 a.m.

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Howard K. Koh, M.D., M.P.H.
Chairman
Public Health Council

LMH/SB -